SECTION 6
COPAYMENT – COINSURANCE

Providers of service are responsible for collecting copayment and coinsurance amounts from recipients, unless otherwise exempt. The provider shall collect copayment or coinsurance from the recipient at the time each service is provided or at a later date. Providers may not deny or reduce services to recipients, otherwise eligible for benefits, solely on the basis of the recipient's inability to pay. Whether or not the recipient is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service. The Medicaid program shall not increase its reimbursement to a provider to offset any uncollected copayment or coinsurance from a recipient.

Copayment

The following copayment amounts are applied to *dental* services; CPT or surgical procedures are not subject to copayment. The amount of copayment to be collected from the recipient is based on the Medicaid reimbursement amount per date of service or item as listed on the following schedule:

Medicaid Reimbursement for Each Item	Recipient Copayment
$10.00 or less	$ .50
$10.01 - $25.00	$ 1.00
$25.01 - $50.00	$ 2.00
$50.01 or more	$ 3.00

Exemptions to Copayment

- Recipients under the age of 19 or receiving Medicaid with ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87 and 88;
- Foster Care recipients under the age of 21 receiving Medicaid with ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Recipients receiving Medicaid services for the blind under ME codes 02, 03, 12 and 15;
- Recipients receiving Medicaid services for pregnant women under ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to MC+ Managed Care enrollees;
- Recipients residing in a skilled nursing facility, an intermediate care nursing facility, a residential care home, an adult boarding home or a psychiatric hospital; or recipients receiving Medicaid under ME codes 23 and 41;
- When coinsurance is charged for dentures

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless one of the following exceptions apply. The amount collected from the recipient is 5% of the lesser of Medicaid's maximum allowable amount or the provider's billed charge.

- Recipients under the age of 19;
- Foster Care recipients under the age of 21
- Recipients residing in a skilled nursing facility, psychiatric hospital, residential care facility or an adult boarding home; and
- MC+ health care plan enrollees for services provided by the plan.

Procedure Code	Medicaid Maximum Allowable
D5110	$ 357.00
D5120	$ 355.00
D5130	$ 361.00
D5140	$ 360.00
D5211	$ 272.00
D5212	$ 276.00
D5213	$ 385.00
D5214	$ 386.00
D5820	$ 286.00
D5821	$ 286.00
D5860	$ 457.50
D5861	$ 457.00

NOTE: Denture procedure codes D5110 through D5821 are a covered service for recipients under the age of 21 or under a category of assistance for pregnant women, the blind or vendor nursing facility residents. Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to recipients under the age of 21.